Supreme Court, U.S.
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IN THE

Supreme Court of the United States

KEITH O'HARA AND ROSS & PINES, LLC,
Petitioners

v.

ZURICH AMERICAN INSURANCE COMPANY ,ET AL.,
Respondents

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the term "appropriate equitable relief" in 29 U.S.C. § 1132(a)(3) imposes equitable limitations on subrogation recoveries that a medical benefit plan may seek from a plan beneficiary.

PARTIES TO THE PROCEEDINGS

Petitioners are Keith O'Hara and the law firm of Ross & Pines, LLC.

Respondents are Zurich American Insurance Company, and Benefits Administration Committee of the Zurich Medical Plan.

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Keith O'Hara and Ross & Pines, LLC, respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a) is reported at 604 F.3d 1232. The opinion of the district court (App., *infra*, 14a-20a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 26, 2010, and a timely petition for rehearing was denied on August 11, 2010. App., *infra*, 21a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The relevant portions of 29 U.S.C. § 1132(a)(3), § 1182(a) and (b), and 29 C.F.R. § 2590.702 are reproduced *infra*, App. 22a-26a.

STATEMENT

This case raises the issue left open in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 368 n.2 (2006): whether the term "appropriate equitable relief" in 29 U.S.C. § 1132(a)(3) imposes equitable limitations on subrogation recoveries that a medical benefit plan may seek from a plan beneficiary. At stake is whether the costs of the primary system of health coverage in America will be spread equitably among all plan participants or will be dispropor-

tionately and inequitably imposed upon the severely injured victims of a third party's negligence.

The decision below directly conflicts with this Court's interpretation of 29 U.S.C. § 1132(a)(3) as imposing equitable limitations on relief available under that section. See Part I.A., *infra*. It allows a plan to enforce any terms of the plan, no matter how inequitable they may be to a participant.

It also directly conflicts with the large body of case law, including cases of this Court, holding that equity requires that insurers and other sureties refrain from exercising rights of subrogation and reimbursement until the prime creditor, here Mr. O'Hara, has been made whole, or, at the least, limiting insurers to a proportional share of medical expenses. See Part I.B., *infra*.

Finally, the decision below conflicts with the statute, 29 U.S.C. § 1182, mandating the equitable provision of health benefits and the spreading of their costs among all plan participants by prohibiting discrimination against participants like Mr. O'Hara. See Part I.C, *infra*.

1. Keith O'Hara was struck head-on at a high rate of speed by a large pickup truck, resulting in serious injuries requiring the amputation of a leg, among other things. He and his wife filed suit for his losses and her loss of consortium. App. 1a-2a. They ultimately settled all claims for $1,286,457.11, and after deducting for attorney's fees and the portion compensating his wife, Keith O'Hara received $618,930.23 as a net recovery. App. 2a, 15a, 30a. Mr. O'Hara's injuries were so traumatic that the parties stipulated that

he was not made whole by this settlement. App. 2a, 28a.

Mr. O'Hara's wife was an employee of respondent Zurich American Insurance Company, and Zurich's self-funded health plan paid some $262,611.92 of Mr. O'Hara's medical expenses. Zurich sought full reimbursement of this sum from Mr. O'Hara under terms of the plan set out in the opinion below. App. 2a-4a. In this regard, the plan treats its beneficiaries differently, depending on whether they recover compensation from a third party who is responsible for their injuries. Those who receive no such recovery need not reimburse the plan for medical payments. Those who recover compensation from a third party, however, must reimburse the plan in full, up to the amount of the recovery, even if they are not compensated for their other losses, i.e., even if they are not made whole. *Id.* In short, the former owe no further contributions to the plan from their personal estates, but the latter do.

2. The funding of the plan was relevant to the respective equities of Zurich, Mr. O'Hara, and other beneficiaries of the plan. Funding came from employee contributions and from Zurich. The employee contributions were set by Zurich at 22% of the projected cost of the benefits for the next year. Whatever the ultimate cost of those benefits happened to be, above or below the projected cost, Zurich would pay the difference from its own funds, reducing its profit accordingly. App. 27a. As an illustration stipulated by the parties, if the anticipated cost of benefits for a year is $1,000, the target

contribution for employees would be roughly $220, and Zurich would pay the difference between the contributions it collects from its employees and the actual cost of the benefits, whether the actual cost is greater than or less than $1,000. *Id.*

Subrogation recoveries reduce the amount that *Zurich* (not its employees)[1] must contribute to the Plan in a given year. App. 28a. Using the same illustration for the years of 2000 and 2001, the parties stipulated that if Zurich pays medical benefits of $1,000 in 2000, and if Zurich recovers $500 under its right of reimbursement in 2001 for expenses paid in 2000, the amount it must pay for benefits in 2001 is the difference between (a) the actual cost of the benefits incurred in 2001 and (b) the $220 in contributions (premiums) collected *plus* the $500 in reimbursements recovered. *Id.* Employees pay the same 22% of expected benefits whether the plan recovers from the tort victim or not, but tort victims also shoulder an additional burden that Zurich would otherwise pay. The $500 in this illustration affects Zurich's bottom line in the same way that $500 of extra income does. The intended effect on persons like Mr. O'Hara is that Zurich collects their premiums, but pays no net benefits.

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[1] The stipulation contained the only evidence regarding the operation of this plan, and thus there is no basis for the claim of the court of appeals that reimbursement in these cases inures to the benefit of all participants and beneficiaries, who would pay more if reimbursement were disallowed here. App. 10a.

3. Zurich filed suit against Keith O'Hara and his counsel under ERISA, 29 U.S.C. § 1132(a)(3), seeking full reimbursement of its medical payments from his recovery in tort. After a period of discovery, the parties made a stipulation of facts and filed cross motions for summary judgment. The district court granted Zurich's motion and denied O'Hara's motion. App. 14a-20a.

4. The Eleventh Circuit affirmed. On the central claim that 29 U.S.C. § 1132(a)(3) statutorily limited Zurich's relief to "appropriate equitable relief," and that equity would apply a make-whole rule in this case, the court of appeals reasoned that such a limitation would amount to allowing "federal common law to override the Plan's controlling language" and "frustrate, rather than effectuate" the purpose of protecting "contractually defined benefits." App. 8a. It argued that the only role for a make-whole rule is as a default rule of plan interpretation, App. 6a-7a, rejecting O'Hara's reference to decisions of the majority of courts applying the make-whole rule as an equitable limitation on subrogation recoveries. The Court also considered and rejected other potential equitable limitations on the Plan's recovery, including the common fund doctrine and a *pro rata* theory. App. 9a.

REASONS FOR GRANTING THE WRIT

Whether the costs of the American employment-based system of health care are to be spread equitably among employees or disproportionately cast upon the catastrophically injured, is an issue of extraordinary

importance. The subrogation industry's statistics are not available for public scrutiny, but some of its members have told this Court that "[m]illions and potentially billions of dollars are recouped annually by health plans and insurers by virtue of subrogation and other recovery mechanisms." Amicus Brief of America's Health Insurance Plans, Inc., et al., at 10 in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002). This range is corroborated by the number of workers covered, about 137 million,[2] and the Secretary of Labor has cited a report that the largest subrogation service recovered at a rate of $4.80 per covered member.[3] However, instead of spreading this $4.80 evenly among covered members, subrogation practices place the disproportionate burden upon the victims of negligence, driving them closer to dependency on public medical assistance, while the plans' sponsors pocket the recovery to improve their own bottom lines, as Zurich does here (see 3-4, *supra*). Numerous authorities recognize that subrogation recoveries are windfalls for the insurers.[4]

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[2] *Fact Sheet: Workers' Right to Health Plan Information*, http://www.dol.gov/ebsa/newsroom/fserisa.html (last viewed November 1, 2010).

[3] Brief of Labor Secretary at 13 in *QualChoice, Inc. v. Rowland*, 367 F.3d 638 (6th Cir. 2004), available at http://www.dol.gov/sol/media/briefs/qualchoice(A)-6-17-2004.pdf (last viewed October 31, 2010).

[4] See authorities cited in Comment, *Insurer's Right of Subrogation Against Insured Who Has Recovered a General Verdict*, 42 Colum. L. Rev. 1368, 1371 n. 12 (1942), and

Subrogation practices compel the injured victim and the public to subsidize private profit.

As documented more fully in the following, the decision below conflicts with the statute limiting plans to "appropriate equitable relief" and this Court's consistent interpretation of that statute. It conflicts with other statutes forbidding inequitable discrimination against people like Mr. O'Hara in requiring them to pay more for their coverage than similarly situated beneficiaries pay. It also conflicts with a large body of case law recognizing that equitable principles limit recoveries by entities like Zurich in cases where, as here, the victim has not been made whole.

This Court's decision in *Sereboff* did not resolve these issues. As the lower court phrased it, *Sereboff* decided that ERISA-governed plans could state a claim that "sounds in equity," App. 5a, and it decided that a claim based on an equitable lien by agreement would not require that the disputed money could be "traced" back to the plan, which is a requirement for those equitable liens that are created by courts of equity to remedy unjust enrichment. *Sereboff*, 547 U.S. at 364-366. Unlike *Sereboff*, in which "[n]either the District Court nor the Court of Appeals considered the argument" that the statutory phrase "appropriate equitable relief" limited relief that the Plan could recover (*id.* 368 n.2), the issue was raised

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Brendan S. Maher & Radha A. Pathak, *Understanding and Problematizing Contractual Tort Subrogation*, 40 Loy. U. Chi. L. J. 49, 85 n.166 (2008).

and resolved at all levels here. App. 6a-9a, 17a-18a. In short, though enforcement of an equitable lien by agreement is equitable as opposed to *legal* relief, it is not for that reason equitable as opposed to *inequitable* relief. Such enforcement is an instance of specific performance,[5] which is never automatic, but always subject to a review of all equitable considerations. *Texas v. New Mexico*, 482 U.S. 124, 131 (1987).

I. The decision below conflicts with this Court's decisions in *Harris Trust* and *Great-West* and the requirement that any relief be "appropriate equitable relief."

A. Under 29 U.S.C. § 1132(a)(3), common law equitable principles limit relief that may be obtained.

The decision below directly contradicts a series of cases in which this Court has held that common law equitable principles limit relief available under 29 U.S.C. § 1132(a)(3), the provision under which Zurich seeks to recover in this case. Ignoring the authority of Congress and this Court's interpretations, the lower court allows a Plan to contract away this statutory limit and enforce terms regarded as inequitable for over a century.

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[5] Harlan F. Stone, *The "Equitable Mortgage" in New York*, 20 Colum. L. Rev. 519, 521 (1920) (equitable liens by agreement "in the final analysis will be found to be a special application of the doctrine of specific performance to agreements to give security.")

The first case in this series was *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993), in which the Court rejected a broad interpretation of "equitable relief" that would make the term "equitable" superfluous, holding that it referred to "categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.* 256-257.

Later, in *Varity Corp. v. Howe*, 516 U.S. 489 (1996), in the course of authorizing reinstatement as equitable relief under 29 U.S.C. § 1132(a)(3), the Court rejected a counter-argument that such a claim for individuals would impose a standard incompatible with an existing claim for the benefit of the Plan itself under 29 U.S.C. § 1132(a)(2) (*id.* at 513-514) by holding that the word "appropriate" in "appropriate equitable relief" is a term of limitation.

> We should expect that courts, in fashioning "appropriate" equitable relief, will keep in mind the "special nature and purpose of employee benefit plans," and will respect the "policy choices reflected in the inclusion of certain remedies and the exclusion of others." [Cits.] Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate." [Cit.]

Id. at 515. *Varity* teaches that such relief cannot be automatic. It is "fashion[ed]," and a district court may refuse where it is not "appropriate." *Id.*

Directly on point, this Court stated that common law limitations inhere in 29 U.S.C. § 1132(a)(3) in *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000). After holding that an ERISA fiduciary could seek relief under 29 U.S.C. § 1132(a)(3) against its broker for selling worthless properties to the trust (*id.* at 245-249), the Court rejected the counter-argument that this construction would allow a fiduciary to sue innocent parties:

> But this reductio ad absurdum ignores *the limiting principle explicit in § 502(a)(3): that the retrospective relief sought be "appropriate equitable relief."* The common law of trusts, which offers a "starting point for analysis [of ERISA] ..., plainly countenances the sort of relief sought by petitioners against Salomon here. ... *[T]he common law of trusts sets limits on restitution actions against defendants* other than the principal "wrongdoer." Only a transferee of ill-gotten trust assets may be held liable, and then only when the transferee (assuming he has purchased for value) knew or should have known of the existence of the trust and the circumstances that rendered the transfer in breach of the trust. Translated to the instant context, the transferee must be demonstrated to have had actual or constructive knowledge of the circumstances that rendered the transaction unlawful.

Id. at 250, 251 (emphasis added) (citing five common law treatises as authorities). The Court referred to this analysis as "our interpretation of § 502(a)(3) *to*

incorporate common-law remedial principles." *Id.* at 252 (emphasis added).

In the next major case, *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), this Court held that a Plan's claim for reimbursement from a tort recovery did not seek "appropriate equitable relief," because 29 U.S.C. § 1132(a)(3) "*contain[s] the limitations upon its availability that equity typically imposes*." *Id.* at 211, n.1 (emphasis added). Such "limitations" (plural) include the equitable principles and defenses noted in the standard treatises on equity that the Court has commended in this context:

> Congress felt comfortable referring to equitable relief in this statute – as it has in many others – precisely because *the basic contours of the term are well known*. Rarely will there be need for any more "antiquarian inquiry" ... than consulting, as we have done, standard current works such as Dobbs, Palmer, Corbin, and the Restatements, which make the answer clear.

Id. at 217 (footnote omitted) (emphasis added).

This Court's final decision in this series, *Sereboff v. Mid Atl. Med. Servs., Inc.*, 547 U.S. 356 (2006), did not address whether the make-whole rule was a limitation on reimbursement because the issue had not been raised below. *Id.* at 368, n.2. But consistently with the foregoing holdings, it looked to common law decisions and authorities (citing Dobbs, Palmer, and Pomeroy as authoritative) to determine whether a different asserted common law limitation on the plan's rights of recovery ("tracing") existed.

Id. at 363-368.

The decision below, and several others that ignore the common law limitations on recoveries in cases such as this, directly conflict with this Court's interpretation of 29 U.S.C. § 1132(a)(3) that common law equitable principles limit relief under ERISA. This conflict is ripe for determination.

B. Established equitable principles preclude subrogation recoveries in cases where the victim has not been made whole.

The decision below is not merely in conflict with this Court's interpretation of 29 U.S.C. § 1132(a)(3), but with the vast body of law requiring that a surety or insurer like Zurich refrain from exercising its rights to subrogation or reimbursement unless the primary creditor or victim has been made whole. Courts guided by equitable principles have enforced this limitation for well over a century.

> [T]he right of a subrogee to have the principal obligation and its securities actually applied for his own benefit does not arise until the creditor has been paid in full ... .

5 Pomeroy, *Equity Jurisprudence* § 2350 (4th ed. 1919), citing numerous cases. This is still the prevailing law. *Appleman on Insurance* §§ 6509, 6572 (1981); *Couch on Insurance*, § 223:133 (3d ed. 2000). This Court has also recognized this "familiar rule of the law of subrogation":

> [A] surety liable only for part of the debt does not become subrogated to collateral or to remedies available to the creditor unless he pays

the whole debt or it is otherwise satisfied. *United States v. National Surety Co.*, 254 U.S. 73, 76 (1920). The Court explained that this rule is based "in the principle of equitable subrogation," and it prevents a "competition" between creditors and the sureties who have undertaken to protect them. *Id.* at 137. *American Surety Co. v. Westinghouse Electric Mfg. Co.*, 296 U.S. 133, 137 (1935). This "familiar equity rule" prevents a surety from "defeat[ing] the purposes for which he has given the indemnity." *Prudence Realization Corp. v. Geist*, 316 U.S. 89, 96 (1942).

In the context of insurance, chiefly in property loss cases, equity created a right of subrogation where the insurer indemnified all of the insured's losses even without contractual subrogation rights, but only to the extent the insured had been made whole.[6] In the context of life and casualty insurance, no similar right of subrogation arose because insurance payments in those cases did not indemnify the very different liability of the tortfeasor who caused death or bodily injury.[7]

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[6] See, e.g., *Newcomb v. Cincinnati Ins. Co.*, 22 Ohio St. 382, 388 (Ohio 1872) ("the assured will not, in the forum of conscience, be required to account for more than the surplus, which may remain in his hands, after satisfying his own excess of loss in full"); *Garrity v. Rural Mut. Ins. Co.*, 253 N.W.2d 512, 514-516 (Wis. 1977) (discussing numerous authorities).

[7] See, e.g., *Gatzweiler v. Milwaukee E. R. & L. Co.*, 116 N.W. 633, 634 (Wis. 1908) (life); *Suttles v. Railway Mail Ass'n*,

In the specific context of health insurance benefits, no court has ever recognized an *equitable* right to subrogation for the same reason, and no claims for *contractual* subrogation were enforced until 1954.[8] Although most courts have upheld contractual subrogation terms in health plans since 1954, all of the courts that were guided by equitable principles[9] have imposed a make-whole limitation on the recoveries. A subrogation claim against the insured –

> is limited (a) to that part of the recovery which the claimant establishes was in compensation for the same loss, and (b) to that part of the victim's total net compensation for that loss which is in excess of full compensation.

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141 N.Y.S. 1024, 1025-1026 (N.Y. App. Div. 1913) (disability); *Crab Orchard Improv. Co. v. Chesapeake & O. R. Co.*, 115 F.2d 277, 281 (4th Cir. 1940) (workers compensation).

[8] 4 Palmer, *Law of Restitution* § 23.18 (1978), at 458, citing *Michigan Med. Service v. Sharpe*, 64 N.W.2d 713 (Mich. 1954).

[9] These are the relevant courts because under 29 U.S.C. § 1132(a)(3), as interpreted by this Court, common law equitable principles incorporated into the statute prevail over contract terms. See Part I.A., supra. Even without such a statute dictating the outcome, a 1994 survey showed that equitable make-whole principles controlled in the majority of states that reached the issue, while only a few states let insurers contract away equitable limitations. Elaine M. Rinaldi, *Apportionment of Recovery Between Insured and Insurer*, 29 Tort & Ins. L. J. 803, 807, 811, nn. 19-43, 64-69 (1994). Since then, as shown below, more states have joined the majority.

4 Palmer, *Law of Restitution* § 23.16(b) (1978),[10] at 444; see also *id.* § 23.18(d), at 471-476, noting that the law on this subject was "in its early stages," but that courts were recognizing these equitable limits. Courts continued to do so, as shown in this sequence:

* *Thiringer v. American Motors Ins. Co.*, 588 P.2d 191, 194 (Wash. 1978), held that a policy provision contrary to the make-whole rule "would be obviously unfair, since the insured pays a premium for the PIP coverage and has a right to expect that the payments promised under this coverage will be available to him if the amount he is able to recover from other sources, after diligent effort, is less than his general damages."

* *Wimberly v. American Cas. Co.*, 584 S.W.2d 200, 203 (Tenn. 1979), held that insurance subrogation originates in general principles of equity and in the nature of insurance as indemnifying the insured, precluding recovery "until the whole debt is paid."

* *Rimes v. State Farm Mut. Auto. Ins. Co.*, 316 N.W.2d 348, 353 (Wis. 1982), held that only "where an insured has received full damages from the tortfeasor ... is the insurer, under principles of equity, entitled to subrogation."

* *Powell v. Blue Cross Blue Shield of Alabama*, 581 So.2d 772, 777 (Ala. 1990), held that –

> [The make-whole rule] better reflects the underlying equitable principles that give rise to

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[10] This Court recognized *Palmer* as an authority in *Sereboff*, 547 U.S. at 368.

> the remedy of subrogation itself ... and better reflects the purpose for which one purchases insurance. The very heart of the bargain when the insured purchases insurance is that if there is a loss he or she will be made whole. [Earlier] cases never envisioned the use of subrogation as a device to fully reimburse the insurer at the expense of leaving the insured less than fully compensated for his loss.[11]

The Supreme Court of Georgia, Mr. O'Hara's home state, followed this analysis in *Davis v. Kaiser Found. Health Plan*, 521 S.E.2d 815, 818 (Ga. 1999).

* *Wine v. Globe Am. Cas. Co.*, 917 S.W.2d 558, 562 (Ky. 1996), stated that requiring repayment puts the burden of loss on the party least able to bear it, contrary the equitable principles underlying subrogation, whereas insurer assumed the risk; therefore, at equity, the insured must be fully compensated before the insurer may subrogate. The Supreme Court of West Virginia agreed with this analysis in *Porter v. McPherson*, 479 S.E.2d 668, 673 (W. Va. 1996).

* *Franklin v. Healthsource of Arkansas*, 942 S.W.2d 837, 839-840 (Ark. 1997) held that "the equitable principles and objectives of subrogation are controlling" regardless of "the literal language of an insurance contract," which is "realistically a unila-

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[11] This case was overruled in *State Farm Fire & Cas. Co. v. Hannig*, 764 So.2d 573 (2000), only on grounds that the court would allow insurers to contract around equitable limitations, a possibility foreclosed here by 29 U.S.C. § 1132(a)(3).

teral contract." The Supreme Court of Mississippi followed this reasoning in *Hare v. State of Mississippi*, 733 So.2d 277, 284 (Miss. 1999).

* *Swanson v. Hartford Ins. Co. of Midwest*, 46 P.3d 584, 589 (Mont. 2002), held that the insurer cannot recover until insured is made whole because it assumed the risk, "regardless of contract language to the contrary."

* *Ruckel v. Gassner*, 646 N.W.2d 11, 19 (Wis. 2002), held that a reimbursement clause –

> is inequitable. It is contrary to the most fundamental precepts of subrogation. Subrogation in this circumstance would not avoid double recovery or prevent unjust enrichment of the insured. It would authorize incomplete recovery for the insured and shift loss from the insurer, who was paid to assume loss, to the insured, who paid to protect against loss.

* *Blue Cross and Blue Shield of Neb., Inc. v. Dailey*, 687 N.W.2d 689, 699 (Neb. 2004) held that contractual provisions negating the make-whole rule "are in direct opposition to the equitable principles upon which subrogation is allowed and are therefore unenforceable."

* In a slightly different context, this Court has noted that a rule giving a medical benefits provider absolute priority to seize tort recoveries that compensate for non-medical damages would be "unfair" to a party like O'Hara. *Arkansas HHS v. Ahlborn*, 547 U.S. 268, 288 (2006). The Court endorsed an approach that limited the insurer to recover no more than "that portion of a settlement that represents

payments for medical care." *Id.* at 282. In declining to allow the insurer to "lay claim" to anything more, the Court rejected "[a] rule of absolute priority," which, it said, runs the very real risk of "preclud[ing] settlement in a large number of cases," and works dramatic inequities "to the recipient in others." *Id.* at 288. Allowing an entity to "share in damages for which it has provided no compensation ... would be absurd and fundamentally unjust." *Id.* In keeping with this principle, Zurich should in no event be permitted to recover more than its pro rata share of whatever portion of Mr. O'Hara's settlement "that represents payment for medical care."

Thus, consistent with this holding and other decisions of this Court, a court applying equitable principles to Zurich's claim should require that Mr. O'Hara be made whole for all of his losses before Zurich's claim will be allowed or, at the least, that Zurich's recovery be limited to its pro rata share of whatever proportion of Mr. O'Hara's recovery was dedicated to medical expenses less fees and costs.

Unlike cases previously presented to this Court, the issues of equitable limitations on recoveries, and the contentions in this petition are ripe for consideration. However, few if any lower federal courts are complying with 29 U.S.C. § 1132(a)(3) and imposing these limits on subrogation recoveries. Although exact numbers are lacking, given the coverage of ERISA plans (see p. 5 n.2, *supra*), it is likely that thousands of claims, if not more, are pending at any given time, and many of those are in litigation. In the face of widespread inequity and non-compliance with

statutory limitations, the Court should grant the writ to review the decision below.

C. ERISA's anti-discrimination provisions provide additional equitable reasons to refuse subrogation relief in the courts below.

Although ERISA does not expressly address subrogation rights, it contains anti-discrimination provisions that inform the Court's analysis of 29 U.S.C. § 1132(a)(3) for two reasons. First, these provisions require equal treatment for plan beneficiaries in terms of the amounts they contribute to the plan and the benefits they receive, and "equality is equity." *Cunningham v. Brown*, 265 U.S. 1, 13 (1924). Second, such policy choices inform the meaning of "appropriate" equitable relief under ERISA. *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996), quoted *supra* at 8-9. The lower court here, and courts across the nation, are failing to enforce this policy of equality when they require tort victims, as here, to bear a disproportionate burden in funding the plan's payments.

In order to ensure that health plans do not discriminate against sicker or more injured employees, and thus to spread the costs of health care more equitably, Congress prohibited plans from discriminating against some participants in terms of their eligibility for benefits or their monetary contributions for the coverage based on "health status-related factors." 29 U.S.C. § 1182(a)&(b). Contrary to such equities, Zurich seeks to make O'Hara contribute more than other plan members for

the same coverage. Instead of spreading the costs of $4.80 per person across all members of the plan, Mr. O'Hara is being required to surrender compensation for his future wages and bodily integrity in sums approximately equal to 21 years worth of premiums. See supra 6-7, App. 28a-29a. Conversely, Zurich seeks to give him less of a benefit (a mere advance to be repaid) than other members, including those who might have been involved in similar wrecks, but who will not make a monetary recovery against a wrongdoer.

The opinion below undermines Congressional intent by finding that this discrimination was not "on the basis of any health status-related factor to be paid out of O'Hara's general assets." App. 11a. If, soon after the wreck, Zurich had demanded that O'Hara pay an additional premium of $262,000 to retain his benefits, that would be an absolutely clear case of a violation of 29 U.S.C. § 1182(b) based on the health status-related factors of "(A) Health status; (B) Medical condition; (C) Claims experience; and (D) Receipt of health care." See 29 C.F.R. § 2590.702 (c)(2)(ii) & (iii)(Example 2) & (d)(3). The only difference between that situation and the instant case is the passage of time and recovering the money to pay the additional premium, money connected with those "health status-related factors." Congress prohibited such discrimination.

The decision below also undermines Congressional intent by characterizing the reimbursement term as a limitation on benefits that "applies uniformly to all participants ... ." App. 12a. Again, if Zurich had told

O'Hara shortly after the wreck that he would have to pay his own medical expenses, but paid the medical expenses of others injured in the same wreck, this would be a clear violation. See 29 C.F.R. § 2590.702 (b)(2)(i)(B) & (D)(Example 5) & (d)(3). The only difference between that situation and the instant case is the passage of time and recovering the money to repay the advance, money connected with the same health factors. Under normal circumstances, there is no principled way to determine ex ante whether the benefits for all employees injured in car wrecks are being "paid" or merely "advanced" at any given time, and thus whether the benefits are actually being applied uniformly. If the uniformity requirement is to have meaning, it must be enforceable from the first moment that benefits become payable; it cannot wait months and years and depend on the contingencies that make the outcome of personal injury litigation so difficult to predict.

The decision below erred in allowing Zurich to discriminate against O'Hara. Because such discrimination is widespread, this Court should grant the writ to vindicate Congress's intent to prohibit such discrimination.

CONCLUSION

For the foregoing reasons, and with so much at stake, the petitioners respectfully request the issuance of a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit.

Respectfully submitted,

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Appendix A

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-16875

ZURICH AMERICAN INSURANCE COMPANY, in its capacity as Administrator of the Zurich Medical Plan, Plaintiff-Appellee,

versus

KEITH O'HARA, ROSS & PINES LLC as trustee of the Keith O'Hara Full Compensation Fund, Defendants-Appellants.

(April 26, 2010)

Before DUBINA, Chief Judge, BIRCH and BLACK, Circuit Judges.

BIRCH, Circuit Judge:

Zurich American Insurance Company ("Zurich"), the sponsor and fiduciary of the Zurich Medical Plan ("the Plan"), filed suit pursuant to section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3), against Keith O'Hara, seeking reimbursement for medical expenses the Plan had paid on O'Hara's behalf after O'Hara was injured in an automobile collision. The district court granted summary judgment in favor of Zurich. We AFFIRM.

I. BACKGROUND

On 22 February 2005, O'Hara, a beneficiary and

covered person under the Plan, sustained serious bodily injuries when the car he was driving was struck head-on by a large pick-up truck. Following the accident, the Plan paid $262,611.92 in medical expenses on O'Hara's behalf. O'Hara later sued the other driver, and the parties to that action settled for $ 1,286,457.11.[1]

After learning of O'Hara's third-party recovery, Zurich attempted to collect the $ 262,611.92 from O'Hara pursuant to the Plan's subrogation and reimbursement provision. It states:

> Immediately upon paying or providing any benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to covered persons, from any or all of the following "Third Parties" listed below.
>
> In addition to any subrogation rights and in consideration of the coverage provided by this Plan, the Plan shall also have an independent right to be reimbursed by covered persons for the reasonable value of any service and benefits the Plan provides to covered persons, from ... [t]hird parties, including any person alleged to have caused a covered person to suffer injuries or damages.
>
> ...
>
> Covered persons agree as follows:
>
> * That a covered person will cooperate with the Plan in a timely manner in protecting

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[1] It is undisputed that O'Hara was not made whole by receipt of the funds under the settlement agreement.

the Plan's legal and equitable rights to subrogation and reimbursement ... .

* That failure to cooperate in this manner shall be deemed a breach of contract and may result in the termination of health benefits and/or institution of legal action against a covered person.
* That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called 'Fund Doctrine' or 'Common Fund Doctrine' or 'Attorney's Fund Doctrine' shall not defeat this right ... .
* That regardless of whether a covered person has been fully compensated or made whole, the Plan may collect from covered persons the proceeds of any full or partial recovery that a covered person or his or her legal representative obtain, whether in the form of a settlement ... or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as noneconomic damage settlement or judgment.
* That benefits paid by the Plan may also be considered to be benefits advanced.
* That covered persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement ... or judgment, the covered person will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as

> a breach of the covered person's duties hereunder.
>
> ...
>
> * That the Plan will also have an equitable lien against any rights the covered person may have to recover the reimbursable expenses from any party, including an insurer or another group health program, but limited to the amount of the reimbursable payments made by the Plan .... This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person or the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's right of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds.

R1-1, Exh. A at 80-82. When O'Hara refused to repay the Plan, Zurich filed suit under ERISA § 502(a)(3), seeking "all appropriate equitable relief" to enforce its right to reimbursement under the Plan. R1-1 at 6. O'Hara's attorneys agreed to place $ 262,611.92 in an interest-bearing trust account pending the outcome of the lawsuit.

On cross-motions for summary judgment, the parties did not dispute that Zurich's action to recover

medical expenses sounded in equity,[2] but quarreled over whether the equitable relief sought in this case was "appropriate" under ERISA § 502(a)(3). The district court granted summary judgment in favor of Zurich, finding that Zurich had a clear and unambiguous contractual right to reimbursement under the Plan. The court further found that the terms of the Plan's subrogation and reimbursement provision expressly disclaimed the "common fund doctrine," thus precluding deduction of attorneys' fees from Zurich's total recovery. R2-61 at 6-8. The court therefore ordered O'Hara to reimburse Zurich for the entire $262.611.92 plus any accrued interest. O'Hara now appeals.

II. DISCUSSION

We review de novo a district court's grant of summary judgment, applying the same legal standards as the district court. See *Nat'l Parks Conservation Ass'n v. Norton*, 324 F.3d 1229, 1236 (11th Cir. 2003). "Sum-

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[2] In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356, 362-64, 368, 126 S. Ct. 1869, 1874-75, 1877, 164 L. Ed. 2d 612 (2006), the Supreme Court held that an action to enforce a plan's reimbursement provision against a beneficiary who is in possession of particular, identifiable funds, sounds in equity and is thus cognizable under §502 (a)(3). *See also Popowski v. Parrott*, 461 F.3d 1367, 1373 (11th Cir. 2006) (plan fiduciary's action to enforce reimbursement provision was properly brought as an action for equitable relief under § 502(a)(3) because the provision "specifie[d] both the fund (recovery from the third party or insurer) out of which reimbursement is due to the plan, and the portion due the plan (benefits paid by the plan on behalf of the defendant)," and because the funds specified were in the beneficiary's possession).

mary judgment is appropriate where 'there is no genuine issue as to any material fact' and 'the moving party is entitled to a judgment as a matter of law.'" *Id.* (quoting Fed. R. Civ. P. 56(c)).

ERISA § 502(a)(3) authorizes a plan fiduciary to bring a civil action "to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or ... to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a)(3) (2009). O'Hara argues that enforcement of the reimbursement and subrogation provision is not "appropriate" because he was not made whole by his third-party recovery.

"Under the make-whole doctrine, an insured who has settled with a third-party tortfeasor is liable to the insurer-subrogee only for the excess received over the total amount of his loss." *Cagle v. Bruner*, 112 F.3d 1510, 1520 (11th Cir. 1997) (per curiam) (quotation marks, citation, and emphasis omitted). We held in *Cagle* that the make-whole doctrine is a default rule that applies only in the absence of specific and unambiguous language precluding it. *Id.* at 1522. See also *Barnes v. Independent Auto. Dealers Ass'n of Cal. Health and Welfare Benefit Plan*, 64 F.3d 1389, 1395 (9th Cir. 1995) (applying make-whole rule where subrogation clause contained no language specifically allowing reimbursement even if beneficiary were not made whole); *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1298-99 (7th Cir. 1993) ("[T]he make-whole rule is just a principle of interpretation [that] can be overridden by clear language in the plan."). The Plan's reimbursement and subrogation provision, which states

that "the Plan may collect from [a] covered person[] the proceeds of any full or partial recovery" he obtains from a third-party tortfeasor, "regardless of whether [the] covered person has been fully compensated or made whole," R1-1, Exh. A at 81 (emphasis added), is clearly sufficient to disclaim any "make-whole" limitation on Zurich's right to reimbursement. *Cf. Cagle*, 112 F.3d at 1521 (concluding that plan's "standard subrogation language" giving plan the right to be reimbursed "in the event [the beneficiary] recovers the amount of medical expense paid by the [plan] ... from any third person" was insufficient to show specific rejection of make-whole doctrine). Because ERISA's primary purpose is to "ensure the integrity of written, bargained-for benefit plans," *United McGill Corp. v. Stinnett*, 154 F.3d 168, 172 (4th Cir. 1998),[3] the Plan must be enforced as written unless the Plan conflicts with the policies underlying

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[3] *See also Longaberger Co. v. Kolt*, 586 F.3d 459, 472 (6th Cir. 2009); *Duggan v. Hobbs*, 99 F.3d 307, 309-10 (9th Cir.1996) (describing ERISA as a "comprehensive statute ... designed to protect the integrity of [employee benefit] plans and the expectations of their participants and beneficiaries."); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Shank*, 500 F.3d 834, 838-39 (8th Cir. 2007) (noting the "primacy of the written plan" under ERISA and rejecting appellant/beneficiary's argument that the make-whole doctrine precluded insurer from exercising its contractual right to recovery); *Van Orman v. Am. Ins. Co.*, 680 F.2d 301, 312 (3d Cir. 1982) ("The Supreme Court has emphasized the primacy of plan provisions absent a conflict with the statutory policies of ERISA.").

ERISA or application of the common law is "necessary to effectuate the purposes of ERISA," *Admin. Comm. of Wal-Mart Stores, Inc. Assocs.' Health and Welfare Plan v. Varco*, 338 F.3d 680, 691-92 (7th Cir. 2003) (quotation marks and citation omitted).

O'Hara contends that, as a matter of equity and in order to effectuate ERISA's policy of protecting plan beneficiaries, the make-whole rule must be applied because allowing Zurich to recoup the medical expenses it paid on his behalf unduly punishes him by requiring him to forfeit a substantial portion of the compensation he received for his other losses, including future wages and bodily integrity, and unjustly enriches Zurich. We disagree.

Applying federal common law to override the Plan's controlling language, which expressly provides for reimbursement regardless of whether O'Hara was made whole by his third-party recovery, would frustrate, rather than effectuate, ERISA's "repeatedly emphasized purpose to protect contractually defined benefits." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148, 105 S. Ct. 3085, 3093, 87 L. Ed. 2d 96 (1985); *see also Varco*, 338 F.3d at 692. Applying federal common law to deny an employer its right to reimbursement pursuant to a written plan would also frustrate ERISA's purposes by "discourag[ing] employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497, 116 S. Ct. 1065, 1070, 134 L. Ed. 2d 130 (1996). *See also Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1452 (4th Cir. 1992) ("[R]esort to federal common law generally is inappropriate when its application would ... discourage employers from implementing plans governed by

ERISA.").[4]

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[4] O'Hara does not explicitly challenge that aspect of the district court's order finding that the Plan precludes deduction of attorneys' fees from Zurich's total recovery. However, to the extent his argument necessarily encompasses such a challenge, we note that because the Plan clearly and unambiguously disclaimed the "common fund doctrine," the district court correctly found that Zurich was owed the entire amount it paid on O'Hara's behalf without a deduction of attorneys' fees. *See, e.g., Health Cost Controls v. Isbell*, 139 F.3d 1070, 1072 (6th Cir. 1997) (where ERISA-regulated employee health benefits plan "expressly require[d] full reimbursement of the Plan for medical benefits when a beneficiary recovers sufficient damages from a third party tortfeasor," and beneficiary failed to show that application of common fund doctrine "would advance any explicit statutory purpose of ERISA," beneficiary had no right to a set-off for legal costs attributable to recovery from a third party); *see also Shank*, 500 F.3d at 839-40 (beneficiary's pro rata theory, under which insurer would receive only partial reimbursement equal to that portion of beneficiary's settlement that compensated her for her medical expenses, failed because beneficiary and insurer expressly and unambiguously agreed that beneficiary would reimburse insurer in full); *Ryan*, 78 F.3d at 127-28 (3d Cir. 1996) (beneficiaries' argument that employee health plan would be unjustly enriched if it was not required to pay a pro rata share of their attorney's fees failed where such enrichment was allowed by the express terms of the plan). As we explained with respect to O'Hara's make-whole theory, applying federal common law doctrines to alter ERISA plans is inappropriate where the terms of an ERISA plan are clear and unambiguous. *See Bill Gray Enterprises, Inc. Employee Health and Welfare Plan v. Gourley*, 248

While we sympathize with O'Hara's situation, we cannot conclude that enforcement of Zurich's contractual right to full reimbursement conflicts with ERISA's policy of protecting Plan beneficiaries or that a balancing of the equities in this case requires application of the make-whole doctrine to defeat the Plan's unambiguous reimbursement requirement. Although O'Hara himself will be in a better position if the subrogation provision is not enforced, plan fiduciaries must "take impartial account of the interests of all beneficiaries." *Varity Corp.*, 516 U.S. at 514, 116 S. Ct. at 1078 (emphasis added). Reimbursement inures to the benefit of all participants and beneficiaries by reducing the total cost of the Plan. If O'Hara were relieved of his obligation to reimburse Zurich for the medical benefits it paid on his behalf, the cost of those benefits would be defrayed by other plan members and beneficiaries in the form of higher premium payments. Plan fiduciaries must also ensure that the assets of employee health plans are preserved in order to satisfy present and future claims. *See id.* Because maintaining the financial viability of self-funded ERISA plans is often unfeasible in the absence of reimbursement and subrogation provisions like the one at issue in this case, *see Shank*, 500 F.3d at 838, denying Zurich its right to reimbursement would harm other plan members and beneficiaries by reducing the funds available to pay those claims. Moreover, O'Hara availed himself of the benefits of the Plan with the knowledge that the Plan

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F.3d 206, 220-21 n.13. (3d Cir. 2001); *Isbell*, 139 F.3d at 1072.

would be entitled to full reimbursement for those benefits in the event he was injured and received full or partial recovery from a third party tortfeasor. As the Third Circuit has pointed out, any inequity in this case would lie in permitting O'Hara "to partake of the benefits of the Plan and then after [he] had received a substantial settlement, invoke common law principles to establish a legal justification for [his] refusal to satisfy [his] end of the bargain." *Ryan v. Fed. Express Corp.*, 78 F.3d 123, 127-28 (3d Cir. 1996); *see also Shank*, 500 F.3d at 839 (enforcement of ERISA plan, which expressly precluded make-whole rule, was "appropriate" where plan "confer[red] benefits on both parties," by requiring payment of premiums plus a promise to reimburse the plan in exchange for the "certainty that the [plan] would pay [beneficiary's] medical bills immediately if [beneficiary] was injured").

Finally, we find no merit in O'Hara's argument that Zurich's claim for reimbursement violates ERISA's anti-discrimination provision in that it forces him to make a greater contribution to the Plan than similarly situated participants and results in his receiving lesser benefits under the Plan than similarly situated participants. ERISA § 702(b)(1) prohibits a group health plan from "requir[ing] any individual ... to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor." 29 U.S.C. § 1182(b)(1). The reimbursement Zurich seeks in this case is not a premium or contribution on the basis of any health status-related factor to be paid out of

O'Hara's general assets. Rather, Zurich seeks to recover specific and identifiable funds, advanced to cover O'Hara's accident-related medical expenses, that are being held in trust by O'Hara's attorneys.

To the extent the reimbursement and subrogation provision is more accurately characterized as a "limitation" or "restriction" on the level of benefits conferred by the Plan under ERISA § 702(a)(2)(B),[5] it is not impermissibly discriminatory because it applies uniformly to all participants and requires reimbursement from any participant or beneficiary who receives medical benefits under the Plan and then subsequently recovers from a third party. *See* 29 C.F.R. § 2590.702(b)(2)(i)(B) (2010) (stating that "benefits provided under a plan ... must be uniformly available to all similarly situated individuals"). The fact that O'Hara is affected by the Plan's right to subrogation, while others who have not received tort recoveries from third parties are not, does not render the Plan discriminatory.

III. CONCLUSION

O'Hara appeals the district court's order granting summary judgment in favor of Zurich and ordering O'Hara to reimburse Zurich for the medical expenses the Plan paid on O'Hara's behalf. Because full reimbursement according to the terms of the Plan's clear and unambiguous subrogation provision is necessary

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[5] ERISA § 702(a)(2)(B) provides that nothing in the statute "prevent[s] ... a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage." 29 U.S.C. § 1182(a)(2)(B).

not only to effectuate ERISA's policy of preserving the integrity of written plans but to protect the interests and expectations of all plan participants and beneficiaries, such relief is both "appropriate" and "equitable" under ERISA § 502(a)(3). Accordingly, the judgment of the district court is AFFIRMED.

Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

No. 1:07-CV-1580-RLV

ZURICH AMERICAN INSURANCE COMPANY, in its capacity as fiduciary of the Zurich Medical Plan and BENEFITS ADMINISTRATION COMMITTEE OF THE ZURICH MEDICAL PLAN, in its capacity as Administrator of the Zurich Medical Plan,
Plaintiffs,
versus
KEITH O'HARA, ROSS & PINES LLC as trustee of the Keith O'Hara Full Compensation Fund,
Defendants.

(November 3, 2008)

ORDER

This is an action under section 502 (a) (3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3), seeking to enforce the reimbursement provisions of an employee health plan. Pending before the court are the plaintiffs' Motion for Summary Judgment [Doc. No. 52], and the defendants' Motion for Summary Judgment [Doc. No. 53].

I. FACTUAL BACKGROUND

On February 22, 2005, Keith O'Hara sustained severe personal injuries in a car accident. At the time,

Mr. O'Hara's wife, Tonja O'Hara, was a Zurich employee, and Mr. O'Hara was a beneficiary, an eligible dependent, and a "covered person" under the Zurich Medical Plan. Following the car accident, the Plan paid $262,611.92 in medical benefits on Mr. O'Hara's behalf.

On December 15, 2005, Mr. O'Hara and his wife filed a personal injury lawsuit against the other driver involved in the car accident and certain other persons. The parties to that action settled. Under their settlement agreement, Mr. O'Hara was paid $911,457.16 by one set of defendants, and Mr. O'Hara and his wife together were paid $25,000 by another insurance company.

The plaintiffs, both fiduciaries of the Plan, invoked the Plan's subrogation and reimbursement provisions and asked Mr. O'Hara to reimburse the Plan from the settlement recovery for the $262,611.92 in benefits it had paid. Mr. O'Hara refused, and this action followed. By agreement of the parties, Mr. O'Hara's attorney has placed the $262,611.92 at issue in a separate interest-bearing account, pending the outcome of this case.

II. LEGAL DISCUSSION

A fiduciary may bring a civil action under § 502 (a)(3) of ERISA "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132 (a)(3). It is undisputed that the Plan is a self-funded plan governed by ERISA. It is also undisputed that the plaintiffs are fiduciaries of the Plan.

Under ERISA, a subrogation action brought by a

plan's fiduciary pursuant to the terms of a plan is equitable in nature because such an action is indistinguishable from an action to enforce an equitable lien established by agreement. *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006). Because subrogation actions are equitable in nature, a cause of action for such a claim exists under ERISA § 502(a)(3). Id.

In order for a fiduciary to prevail on a claim for subrogation under ERISA, it must demonstrate that the explicit language in the plan provides for an equitable lien, or constructive trust. Administrative Committee for the *Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Horton*, 513 F.3d 1223 (11th Cir. 2008). An equitable lien can be established only if the ERISA plan's language identifies "both the fund ... out of which reimbursement is due to the plan and the portion due the plan." *Popowski v. Parrott*, 461 F.3d 1367, 1373 (11th Cir. 2006).The relevant language in the plan reads as follows:

> In addition to any subrogation rights ... the Plan shall also have an independent right to be reimbursed by covered persons for the reasonable value of any services and benefits the Plan provides to covered persons, from ... any person or entity who is liable for payment to a covered person on any equitable or legal liability theory. [T]he Plan will also have an equitable lien against any rights the covered person may have to recover the reimbursable expenses from any party ... but limited to the amount of the reimbursable payments made by the plan.
>
> Summary Plan Description, pps. 80-81.

It is undisputed that such language is sufficient to create an equitable lien. The language clearly specifies that reimbursement may come only from the proceeds of any recovery that a covered person receives from a third party, and it also limits the reimbursement amount to those monies paid by the plan for the covered person's benefit.

The defendants argue that even though the plaintiffs seek "equitable" relief under § 502(a)(3), it is not "appropriate" under that provision in that it contravenes principles like the "make-whole" doctrine. Under the "make-whole" doctrine, "an insured who has settled with a third-party tortfeasor is liable to the insurer-subrogee only for the excess received over the total amount of his loss." *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 39 (11th Cir. 1989). State courts generally treat the make-whole doctrine as a default rule that is read into insurance contracts, except where it is explicitly excluded. *See Fields v. Farmers Ins. Co.*, 18 F.3d 831, 835-36 (10th Cir. 1994) (diversity case listing states that apply the make-whole doctrine as a default rule). However, ERISA preempts, for self-funded health care plans, state anti-subrogation laws such as the make-whole doctrine. See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

The Eleventh Circuit has adopted the make-whole doctrine as a default rule for ERISA cases. *Cagle v. Bruner*, 112 F.3d 1510 (1997). Because the make-whole doctrine is a default rule, the parties can contract out of the doctrine. *Id.* The language in the Plan reads, "[R]egardless of whether a covered person has been fully compensated or made whole, the Plan

may collect from covered persons the proceeds of any full or partial recovery that a covered person ... obtain[s], whether in the form of a settlement ... or judgment." Such language unambiguously shows that the parties contracted out of the make-whole doctrine.

Without the benefit of the make-whole doctrine, the defendants appeal to general principles of equity, arguing that the Plan is in a much better position to bear the cost of his medical expenses than he himself is. Furthermore, the defendant notes that Mrs. O'Hara paid thousands of dollars in order to purchase medical benefits for herself and Mr. O'Hara. Thus, Mr. O'Hara argues that it would not be "fair" or equitable for him to have to reimburse the Plan.

Although the court recognizes the additional financial burden imposed on Mr. O'Hara, this court's equitable jurisdiction does not allow it to ignore the law as established by Congress and the courts. In light of the precedent before this court, it is clear that it must order the defendant to reimburse the plaintiffs to the extent of the expenditures which they made on his behalf.

The only question remaining for this court is to determine whether the plan is entitled to recover the entire $262,611.92, or whether attorney's fees should be deducted from this amount. The United States Supreme Court has said, "[A] litigant or a lawyer who recovers a common fund for the benefit of persons other than himself or his client is entitled to a reasonable attorney's fee from the fund as a whole." *Boeing Co. v. Van Gemert*, 444 U.S. 472, 478 (1980). "The doctrine rests on the perception that persons who obtain the benefit of a lawsuit without contributing to

its costs are unjustly enriched at the successful litigant's expense," id., and is part of the federal common law. *See United McGill Corp. v. Stinnett*, 154 F.3d 168, 173 (4th Cir. 1998). In this case, however, the Plan states, "[N]o court costs or attorneys' fees may be deducted from the Plan's recovery ... [and] any so-called ... 'Common Fund Doctrine' ... shall not defeat this right ... ."

A primary purpose of ERISA is to ensure the integrity and primacy of written plans. See *Health Cost Controls v. Isbell*, 139, F.3d 1070 (6th Cir. 1997). In light of this goal, the plain language of an ERISA plan should be given its literal and natural meaning. See *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486, 489 (1st Cir. 1989). Federal common law merely fills the gaps of ERISA to assist in the interpretation of ERISA plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). However, federal courts may not apply common law theories to alter the express terms of written benefit plans. See *Bollman Hat Co. v. Root*, 112 F.3d 113, 116 (3rd Cir. 1997); *Cinelli v. Security Pacific Corp.*, 61 F.3d 1437, 1444-45 (9th Cir. 1995); *Land v. Chicago Truck Drivers, Helpers, and Warehouse Workers Union (Independent) Health and Welfare Fund*, 25 F.3d 509, 511 (7th Cir. 1994).

Although the Eleventh Circuit has yet to rule on the applicability of the common-fund doctrine to ERISA plans, every circuit to address the question has upheld an ERISA plan's ability to preclude attorney-fee deductions from any subrogation reimbursements. See *Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274 (1st Cir. 2000); *Bollman Hat Co. v. Root*, 112 F.3d 113 (3d Cir. 1997); *United McGill Corp. v.*

Stinnett, 154 F.3d 168 (4th Cir. 1998); *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer, Poirot & Wansbrough*, 354 F.3d 348 (5th Cir. 2003); *Health Cost Controls v. Isabell*, 139 F.3d 1070 (6th Cir. 1997); *Admin. Comm. of Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Varco*, 338 F.3d 680 (7th Cir. 2003).

Based on this overwhelming authority, the court concludes that express language in an ERISA plan can preclude the operation of the common-fund doctrine. Thus, the plaintiffs are entitled to collect the entire $262,611.92, along with any accrued interest, in the account identified by the plaintiffs as "Ross & Pines, LLC, Trustee of the Keith O'Hara Full Compensation Fund."

Therefore, the plaintiffs Motion for Summary Judgment [Doc. No. 52] is GRANTED, and the defendants' Motion for Summary Judgment [Doc. No. 53] is DENIED.

SO ORDERED, this 3rd day of November, 2008.

ROBERT L. VINING, JR.
Senior United States District Judge

Appendix C
Order Denying Rehearing

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-16875

ZURICH AMERICAN INSURANCE COMPANY, in its capacity as Administrator of the Zurich Medical Plan, Plaintiff-Appellee,
versus
KEITH O'HARA, ROSS & PINES LLC as trustee of the Keith O'Hara Full Compensation Fund, Defendants-Appellants.

(August 11, 2010)
ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC

Before: DUBINA, Chief Judge, BIRCH and BLACK, Circuit Judges.

PER CURIAM:
The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:
[Illegible signature]
UNITED STATES CIRCUIT JUDGE

Appendix D
Statutory and Regulatory Provisions Involved

Section 1132 of Title 29 of the United States Code provides in relevant part:

(a) Persons empowered to bring a civil action

A civil action may be brought - ...

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

...

Section 1182 of the same Title provides in pertinent part:

§ 1182. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In eligibility to enroll.

(1) In general. Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions. To the extent consistent with[29 U.S.C. § 1181], paragraph (1) shall not be construed –

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

...

(b) In premium contributions.

(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction. Nothing in paragraph (1) shall be construed –

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

...

29 C.F.R. § 2590.702, which relates to Section 1182, provides in pertinent part:

(b) Prohibited discrimination in rules for eligibility --

(1) In general --

(i) [Stating the general rule of non-discrimination, which is subject to the rest of this subsection.]

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to--

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenroll-

ment) of any individual under the plan.

...

(2) Application to benefits --

(i) General rule --

(A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances).

...

(c) Prohibited discrimination in premiums or contributions – ...

(2) Rules relating to premium rates – ...

(ii) List billing based on a health factor prohibited. However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

...

(d) Similarly situated individuals. The requirements of this section apply only within a group of individuals

who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

...

(3) **Discrimination directed at individuals.** Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

Appendix E
Excerpts from the Stipulation of the Parties

7. Contributions to fund the Plan are provided by the employer, retirees, eligible full-time employees, and terminated employees that elect to participate in the Plan.

8. The amount of these regular contributions is designed to cover qualified participants' benefit payments and the related administrative expenses.

9. Plan contributions and the actuarial present value of the Plan's projected benefit obligations for the following year are based on several years of historical claims and enrollment, employee demographics, administrative expenses, and certain assumptions pertaining to the expected effect of benefit changes (if any) and healthcare inflation rates.

10. Plan contribution rates are set based on the total cost rates by benefit plan and coverage tier. The total target cost for employees has in the past been roughly 22% of the total cost of providing benefits. A particular employee's dollar cost will depend on the benefit plan and coverage tier he or she selects. Zurich contributes all amounts necessary to provide the benefits over and above that amount. To illustrate: if the anticipated cost of benefits for a year is $1,000.00, the target contribution for employees would be roughly $220.00, and Zurich would pay the difference between the contributions it collects from its employees and the actual cost of the benefits, whether the actual cost is greater than or less than $1,000.00.

11. Because Zurich's requirement to contribute all assets needed to pay benefits above the employee

contribution is always triggered in a given year, subrogation recoveries reduce the amount that Zurich is required to contribute to the Plan. Since subrogation recoveries are part of the calculation of paid claims which forms the baseline for the determination of expected claims in succeeding years, they are also taken into account when setting contribution rates for employees and Zurich in those years. To illustrate: using the same assumptions for the years of 2000 and 2001 as in the previous illustration, if Zurich actually pays medical benefits of $1,000.00 in 2000, and if Zurich recovers under its right of reimbursement $500.00 in 2001 for expenses paid in 2000, the amount it must pay for benefits in 2001 is the difference between (a) the actual cost of the benefits incurred in 2001 and (b) the $220.00 in contributions collected plus the $500.00 in reimbursements recovered.

...

16. Mr. O'Hara was not made whole by receipt of the funds under the Release and Settlement Agreement.

17. $262,611.92 represents the amount of accident-related medical expenses paid by the Plan on Mr. O'Hara's behalf.

18. That $262,611.92 portion comes from the October 31, 2006 settlement of the Personal Injury Action, and not from Mr. O'Hara's general assets.

19. Premiums for the Plan's benefits were paid partially by Zurich and partially by Zurich's employee, Tonja O'Hara, the wife of Defendant Keith O'Hara.

20. The premiums were paid as shown in this table:

	Semi-monthly premium		Annual Total		
Year/ Plan	Paid by Emplo-yee	Paid by Emplo-yer	Paid by Emplo-yee	Paid by Employer	Combined
2004/ UHC PPO	98.00	347.49	784.00	2,779.92	3,563.92
2005/ Choice Plus	117.50	377.71	2,820.00	9,065.04	11,885.04
2006/ Choice Plus	114.50	465.44	3,468.00	11,170.56	14,638.56
2007/ Choice Plus HSA	115.50	408.64	2,772.00	9,807.36	12,579.36
TOTAL			9,844.00	32,822.88	42,666.68

21. These premium rates were the same for all of Zurich's employees under the applicable plan, with family coverage, and the same coverage option. However, certain employees receive credits that have the effect of reducing their contribution costs under their plans.

Appendix F

Excerpts from the Declaration of Keith O'Hara

2. As a result of the head-on collision, I suffered the following injuries:

a. A crush injury to the right lower extremity which necessitated amputation of my right leg above the knee. The pictures attached as Pictures 3 and 4 are fair and accurate representations of my leg injuries before and after the amputation.

b. An infected nonunion left ankle and distal tibial fracture, which required fusion.

c. My left tibial plateau was fractured, which required a total knee replacement.

d. A left distal radius fracture dislocation, which required surgery and a percutaneous pinning of the left wrist with application of sugar-tongue splint.

e. A mild traumatic brain injury.

...

5. Bills for my various medical expenses relating to this incident amount to approximately $538,319.93, and I have had substantial out-of-pocket expenses for medical benefits.

...

8. My wife and I filed a suit and ultimately settled our claims. After deduction of costs and fees used to generate a recovery which I had no right to decline to pay, I actually received $558,930.23 (from a Lancer Insurance Company check in the amount of $911,357.16 and a Village Auto Insurance Company check in the amount of $25,000.00), and I received $60,000.00 (from a State Farm check in the amount of $100,000.00).